

Spine History of Illness - New Patient

I certify that the following information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may make in the completion of this form.

Patient Name (Print: First, Middle, Last)

Patient Signature Date

I have reviewed and discussed this form with this patient.

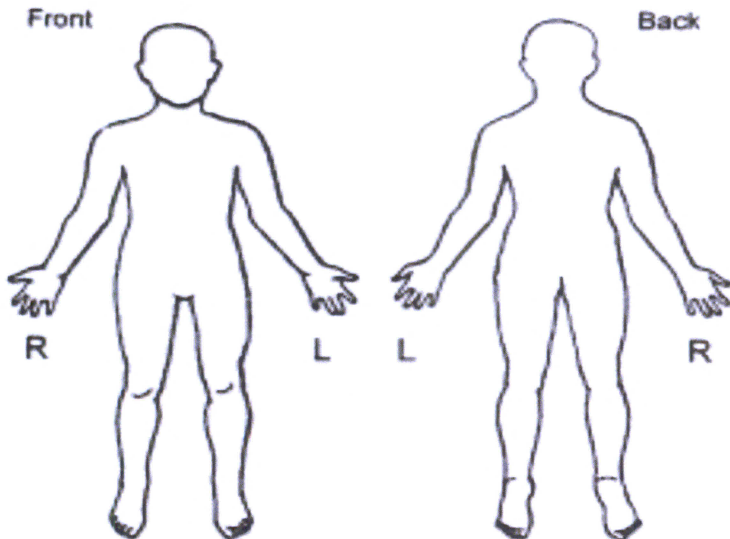
Physician's Signature

List the reason for today's visit (what is the problem?)

✓ Symptoms: (all that apply to today's visit)	Constant	Intermittent	Mark Your Typical Pain Intensity Here										
			← Least Pain Worst →										
			0	1	2	3	4	5	6	7	8	9	10
Neck pain													
Back pain													
Right arm pain													
Left arm pain													
Right leg pain													
Left leg pain													
Weakness			Describe any weakness, numbness or neurologic problems here:										
Numbness													
Balance problems													
Trouble using hands													
Onset of Problem			< 1 month	1- 3 months	3-6 months	6 months - 2 yrs	> 2 yrs						
Approximate duration of current problem													
When did you first seek medical attention?													

Pain Diagram

Using the symbols below, mark the location and type of pain on the diagram on the left. Include all affected areas.



SENSATIONS

aching	^ ^ ^ ^ ^ ^
sharp or stabbing	X X X X X
burning	/ / / / / / / /
pins and needles	- - - - -
numbness	0 0 0 0 0

Please answer the following questions					
	Laying Down	Sitting	Standing	Walking	Bending/Twisting
What makes your symptoms better?					
What makes your symptoms worse?					
Neurologic Functioning	Yes	No	Explain		
Are you losing bowel or bladder control?					
Are you losing control of your arms or hands?					
Are you losing control of your legs or feet?					
Are you noticing problems with "fine motors skills" (i.e. buttoning buttons, opening jars, handwriting)					
Are you noticing difficulties in balance?					
Work					
What is your occupation?					
Are you out of work due to your spinal condition?			How long have you been out of work?		
Do you have a workman's compensation claim?			List date of the work injury		
Previous Treatments	Yes	No		Did treatment help?	
				Yes	No
Have you had physical therapy for your spine?			How long in therapy?		
Have you had epidural injections?			How many?		
Have you had other spinal injections?			What type?		
Have you taken anti-inflammatory medications? (Motrin, Advil, Celebrex, etc...)			List medications		
Have you taken pain medications? (Percoset, Vicodin, Darvocet, Oxycontin, etc...)			List medications		
Have you tried nerve medications? (Neurontin, Lyrica, Cymbalta, etc...)			List medications		
Have you seen a chiropractor?			Chiropractor's name		
Have you tried acupuncture?			Practitioner's name		
Have you tried traction?					
Do you use walking aids? (cane, crutches, walker, wheel chair, etc...)			What type?		
Accidents	Yes	No			
Did your problem begin with an auto accident?			Date of the accident:		
Were you the vehicle driver?					
Were you wearing a seat belt?					
Are you involved in a legal accident claim?			Name of your lawyer:		

Health History New Patient

I certify that the following information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may make in the completion of this form.

Patient Name (Print: First, Middle, Last)	Patient Signature	Date
What is your age?	What hand do you write with? <input type="checkbox"/> Right <input type="checkbox"/> Left	

List ALL your Diagnosed Medical Problems (not just those related to your current office visit)	
<input checked="" type="checkbox"/> if true	I have no known medical problems.

Medications: list ALL that you are currently taking.	Allergies: list ALL medications and foods allergies.
<input checked="" type="checkbox"/> if true I take no medications currently.	<input checked="" type="checkbox"/> if true I have no known allergies.

List ALL prior operations or surgeries you have had (include dates if known).	
<input checked="" type="checkbox"/> if true	I have not had any surgery in the past.

List ALL medical problems in your family or blood relatives: (list the member affected by the medical problem).	
<input checked="" type="checkbox"/> if true	There are no known medical problems in my family.

Please answer the following questions	✓ yes	✓ no
Do you smoke cigarettes?		
If so, how many packs per day?		
How many years have you been smoking?		
Do you smoke a pipe or cigars?		
Do you dip snuff or chew tobacco?		
Do you drink alcohol?		
How often and how much alcohol do you drink?		
Do you use any street drugs?		
If so, which drugs do you use?		
Who do you live with?		

REVIEW OF SYSTEMS (ROS) Please ✓ symptoms you currently have or have had in the past year				
General	Eye, Ear, Nose, Throat	Musculoskeletal	Psychiatric	
Fevers or Chills	Difficulty swallowing	Joint pains	Anxiety	
Dizziness	Hearing loss	Muscle aches	Depression	
Fainting spells	Hoarseness	Ankylosing spondylitis	Psychiatric hospitalization	
Fatigue	Nose bleeds	Weak bones	Panic attacks	
Frequent headaches	Ringling in ears	Rheumatoid arthritis	Suicidal thoughts	
Insomnia	Sinus problems	Osteoarthritis	Psychiatric drugs	
Sweats	Vision-blurred	Bone cancer	Memory loss	
Weight changes	Poor vision	Bone infections	Other:	
Other:	Other:	Other:	MEN only	
Cardiovascular	Gastrointestinal	Genito-Urinary	Breast lumps	
Ankle swelling	Poor appetite	Bladder control	Enlarged prostate	
Chest pains	Bowel changes	Blood in urine	Erectile dysfunction	
Enlarged heart	Constipation	Frequent urination	Penis discharge	
Heart attack	Diarrhea	Kidney stones	Prostate cancer	
Heart murmur	Excessive thirst	Painful urination	Other:	
Heart palpitations	Heartburn	Urgent urination	WOMEN only	
High blood pressure	Nausea	Weak stream	Abnormal Pap Smear	
Shortness of breath	Rectal bleeding	Other:	Breast Lumps	
Irregular heart beat	Stomach pain	Neurological	Vaginal Discharge	
Prolonged bleeding	Ulcers	Loss of fine motor control	Severe menstrual pain	
History of blood clots	Vomiting	Weakness	Hot flashes	
Other:	Other:	Paralysis	Other:	
Endocrine	Skin	Poor balance	Date of last period:	
Blood sugar problem	Bruise easily	Seizures	Age periods began:	
Use of steroids	Foot ulcers	Speech difficulties	Age of menopause:	
Over Active Thyroid	Rashes	Tremors	Are you pregnant?	
Under Active Thyroid	Sores that won't heal	Muscle wasting	# of pregnancies:	
Other:	Other:	Other:	# of live births:	

Height	
Weight	

Welcome To Our Office

New Patient Information

Date _____

PATIENT'S NAME (PLEASE PRINT) (FULL NAME)		NICKNAME	S.S.#	Age	SEX M F	DOB
STREET ADDRESS			CITY AND STATE		ZIP	
HOME PHONE	CELL PHONE	E-MAIL			MARITAL STATUS S M W D	
PATIENT'S EMPLOYER		OCCUPATION (INDICATE IF STUDENT)			BUS. PHONE	EXT
EMPLOYER'S STREET ADDRESS			CITY AND STATE		ZIP	
CONTACT PERSON'S NAME IN CASE OF EMERGENCY			PHONE			

SPOUSE OR PARENT'S NAME	SPOUSE OR PARENT'S NAME S.S.#	BIRTHDATE
SPOUSE OR PARENT'S EMPLOYERS	EMPLOYER'S STREET ADDRESS	BUS. PHONE EXT
SPOUSE'S STREET ADDRESS	CITY AND STATE	ZIP

NAME AND ADDRESS OF REFERRING PHYSICIAN	NAME AND ADDRESS OF PRIMARY CARE PHYSICIAN (FAMILY DR.)
--	--

PERSON RESPONSIBLE FOR PAYMENT	STREET ADDRESS, CITY, STATE	ZIP	HOME PHONE
---------------------------------------	------------------------------------	------------	-------------------

PRIMARY INSURANCE CO. NAME	CERTIFICATE #	GROUP #
POLICYHOLDER'S NAME	POLICYHOLDER'S BIRTHDATE	
SECONDARY INSURANCE CO. NAME	CERTIFICATE #	GROUP #
SECONDARY INS. POLICYHOLDER'S NAME	SECONDARY INS. POLICYHOLDER'S BIRTHDATE	

WHAT ARE YOU SEEING THE DOCTOR FOR TODAY?	DATE OF ONSET	DESCRIPTION OF PROBLEM OR INJURY
IF THIS IS A WORK RELATED INJURY (PLEASE FILL OUT THIS SECTION)		BRIEF DESCRIPTION OF HOW ACCIDENT HAPPENED
NAME OF EMPLOYMENT WHERE INJURY HAPPENED?		COMPLETE ADDRESS OF THAT EMPLOYER
WAS AN AUTOMOBILE INVOLVED? <input type="checkbox"/> YES <input type="checkbox"/> NO STATE _____	DATE OF ACCIDENT	NAME OF ATTORNEY

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES AND COPAYMENTS REGARDLESS OF INSURANCE COVERAGE. IT IS ALSO CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH OUR OFFICE PERSONNEL.

VERY IMPORTANT:
PLEASE BRING INSURANCE CARDS, XRAY'S, MRI AND ANY OFFICE NOTES RELATING TO TODAY'S VISIT.

Authorization to release PHI (Personal Health Information)

I hereby authorize Southeastern Orthopaedic Specialists, P.A. to release my PHI to:
(EXCLUDES PHYSICIANS & ATTORNEYS)

Name of person that information may be released to:
(i.e. spouse, parent, guardian, sibling, etc.)

Address

Patient's Name: _____ Date of Birth: _____

Address: _____

Patient's Signature: _____ Date: _____

Relationship to Patient: _____

Type of information that may be released:
(financial, medical information, information for a specific problem)

Expiration Date: _____

To revoke this authorization, it must be submitted in writing to Southeastern Orthopaedic Specialists, P.A.

There is potential for re-disclosure once this information is disclosed. SOS cannot control what the other entity does with your PHI (Personal Health Information).



**Guilford Orthopaedic and Sports Medicine Center
A Division of Southeastern Orthopaedic Specialists
1915 Lendew Street
Greensboro, NC 27408**

Patient's Name: _____

Patients Ins: _____

Date of First Service: _____

During the past three years, have you had treatment by an Orthopaedic Surgeon in Greensboro?

Yes _____

No _____

If yes, please indicate the name of the physician and/or practice below:

Name of Doctor and/or Practice

Date of Service

Patient Signature

Date

* * Please fill out and bring to your appointment. Thank you! * *



ePrescribing

Guilford Orthopaedic and Sports Medicine, A Division of Southeastern Orthopaedic Specialists are in the process of implementing ePrescribing in each of our offices.

ePrescribing is a federally mandated initiative that requires all physicians prescribe in this manner by 2011.

ePrescribing software sends prescriptions over the internet to your pharmacy in a safe secure way, through the same technology used by credit card companies. This helps protect the privacy of your personal information.

ePrescribing software also lets your doctor see important information-like drug interactions and your prescription history.

The benefits to you:

- Less confusion over handwritten prescriptions or unclear phone calls.
- Reduced possibility of medical errors.
- Less chance of adverse drug reactions.
- Fewer trips to drop off at the pharmacy.
- A safer, faster, easier way to get your prescriptions filled.

Patient Consent:

I agree that Guilford Orthopaedic and Sports Medicine, A Division of Southeastern Orthopaedic Specialists may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

Patient Signature

Date

Printed Name



Account # _____



Meaningful Use Documentation

Language:

English

Spanish

American Sign

French

Japanese

Other

Race:

American Indian

Asian

African American

Native Hawaiian

White

Type Unknown

Ethnicity:

Hispanic Origin

Non-Hispanic Origin

Type Unknown

Decline: _____

***** Must update in C&S *****

Updated by: _____



Southeastern Orthopaedic Specialists, PA

Financial & Insurance Policies

**Murphy Wainer Orthopedics, Sports Medicine and Joint Replacement Center,
Guilford Orthopaedics & Sports Medicine Center, Piedmont Orthopedics**

Insurance co-pays are due at the time of your appointment and will be collected at check in. Your insurance policies may require you to make a copayment for an office visit and/or medical service, therefore payment is required on the date of service.

A \$20.00 service fee will be charged if the co-pay is not paid at the time of service.

The payment collected at the time of service is an estimate based on the information available to us at the time of service. Any remaining balance after the patient's insurance processes and pays the claim is the responsibility of the patient.

No show fee of \$25.00 may be charged for a missed appointment not cancelled 24hrs in advance of appointment.

Urgent Care Visits: \$50.00 fee will be charged to your insurance which may or may not cover this fee. You will be responsible for any portion not covered by your insurance.

We are contracted with most major insurance carriers. **It is the patient's responsibility to verify benefits/limitations and physician participation with their carrier.** Many insurance companies require authorization for visits. If required, please obtain authorization prior to your visit. **Failure to provide authorization may result in the rescheduling and/or cancellation of your appointment.** There may be services provided that your insurance carrier will not cover. Please verify and understand your benefits. **You agree to pay any portion not covered by your insurance carrier.**

Payment requirements if you have NO insurance: A minimum deposit of \$250.00 is required at check in of the initial visit. All other charges are due at time of service unless other arrangements are approved by us in advance in writing.

Patient Balances: When you receive a statement from our facility, payment is due upon receipt of the statement, unless other arrangements have been approved by the facility in writing.

A \$25.00 service fee will be charged for returned checks. This charge will be applied to your account and is due immediately.

Collection Agencies: Patients who do not respond to our efforts to collect an overdue balance may be turned over to an outside collection agency. If this becomes necessary, we will attach a 25% collection fee.

All patients are required to present with a valid Photo ID at check in. A minor child (under 18) must be accompanied by a parent or legal guardian who will present their Photo ID. **NEW PATIENTS UNDER THE AGE OF 18 MUST BE ACCOMPANIED AT THE FIRST VISIT WITH PARENT OR LEGAL GUARDIAN.** At the follow up appointment the MINOR may attend themselves **WITH A WRITTEN STATEMENT PROVIDING AUTHORIZATION TO TREAT MINOR WITHOUT PARENT OR GUARDIAN. This would be required at each visit.**

Divorce: In cases of divorce or separation, the parent authorizing treatment for the child/children will be the parent responsible for charges. If the divorce decree requires the other parent to pay all or part of the treatment cost, **it is the authorizing parent's responsibility to collect from the other parent.**

I have read this Financial Policy and understand that I am ultimately responsible for the charges incurred.

Patient Name: _____

Parent/Guarantor Signature: _____ **Date:** _____